# Exhibit B

MUNSON HEALTHCARE
Home Health

Patient Name: JOHNSON, RICK DOB: [redacted]

**Consent and Plan of Care**

I consent and authorize Munson Home Care, its' agents, and associates to provide care and treatment as prescribed by my provider. I have received an explanation of the services. I agree and consent to the home care plan and payment as outlined in the admission booklet. I understand that this is the initial plan of care, and I will be notified by the agency in advance each time there is a change made to my plan of care.

☑ I agree my treatment plan may include admission in the Telehealth/Remote Patient Monitoring Program.

**Proposed Frequency/Duration of Planned Visits**

| | |
|---|---|
| ☑ Nursing | 3WK1, 2WK1, 1WK4, 2 PRN FOR UNCONTROLED BLEEDING, S |
| ☐ Physical Therapy | |
| ☐ Home Health Aide | |
| ☐ Social Work | |
| ☐ Occupational Therapy | |
| ☐ Speech Therapy | |

**Release of Information**

My medical record containing personal medical information is strictly confidential and protected by federal and state law. I understand that it may be necessary to provide limited medical information and instruction to my designated caregiver(s) to properly and safely assist me with my medical care at times Munson Home Care is not present in my home to assist me.

I authorize Munson Home Care to release the minimum necessary medical information about me to community service organizations to enhance the continuity of care. I understand that medical information released may include information regarding current diagnosis such as HIV/AIDS, appointment reminders or appointment scheduling, treatment plan, and restrictions. This authorization is not sufficient to release behavioral health, drug or alcohol treatment records or hardcopy of the full medical record.

I will provide Munson with the name(s) of my designated caregiver(s) and inform Munson Home Care of any changes, as necessary. I understand that this authorization to release information can be revoked by me in writing at any time.

| | |
|---|---|
| Name [redacted] | Relationship [redacted] |
| Name | Relationship |
| Name | Relationship |
| Name | Relationship |

CONTINUE →

Patient Name: JOHNSON, RICK DOB: [redacted]

**Authorization for Payment/Financial Responsibility**

Munson Home Care will bill your insurer directly for the services provided. This authorization allows Munson Home Care to release necessary medical information to your insurer and to collect payments on your behalf. I understand that I am responsible for any health insurance deductibles or co-pay amounts. I understand that I may request financial assistance from Munson Home Care if I have limited insurance coverage or financial resources.

**Infection Control**

Michigan law provides that I, the patient, may be tested for the presence of HIV or HIV antibody or hepatitis without my written consent. This would occur if an employee or agent of Munson Home Care sustains a puncture wound, mucous membrane or open wound exposure to my blood or other bodily fluids.

**Information Received**

I have discussed with Munson Home Care staff and have understood and received copies as part of the Munson Home Care Admission Booklet the following before accepting service from Munson Home Care:

- Privacy Notices-OASIS
- Advance Directives
- Complaint Process
- Emergency Plan
- Statement of Rights and Responsibilities
- Notice of Privacy Practices-HIPAA
- Federal/State funded Entities for Patient's Location
- Discharge Plan
- Reviewed and understand my insurance benefit letter that identifies charges for services that will not be covered by Medicare, Medicaid, or my current insurance and charges that I may have to pay.

| | | |
|---|---|---|
| RICK JOHNSON<br>Patient/Legal Guardian/DPOA Name Printed | Rick Johnson<br>Signature of Patient/Legal Guardian/DPOA when applicable | 10/9/23 1600<br>Date/Time |
| ALICIA MITCHELL RN<br>Clinician Printed Name | Alicia Mitchell RN<br>Clinician Signature | 10/9/23 1600<br>Date/Time |
| Verbal Consent Witness Printed Name | Verbal Consent Witness Signature | Date/Time |

If Patient unable to sign, state reason: _____

# Patient Instructions Report



## RICK V. JOHNSON - DOB: [redacted]

[redacted]

Share any questions or concerns you have with your health care team.

MUNSON HOME CARE - MANISTEE, (800) 252-2065

Branch Contact: _____

| Dates of Service: 10/09/2023 - 12/07/2023 | | Visit Frequency/Schedule | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Week** | **Week Dates** | **Skilled Nurse** | **Physical Therapist** | **Occupational Therapist** | **Speech Therapist** | **Medical Social Worker** | **Home Health Aide** | **Other** |
| Week: 1 | 10/09/2023 to 10/14/2023 | 3 | | | | | | |
| Week: 2 | 10/15/2023 to 10/21/2023 | 2 | | | | | | |
| Week: 3 | 10/22/2023 to 10/28/2023 | 1 | | | | | | |
| Week: 4 | 10/29/2023 to 11/04/2023 | 1 | | | | | | |
| Week: 5 | 11/05/2023 to 11/11/2023 | 1 | | | | | | |
| Week: 6 | 11/12/2023 to 11/18/2023 | 1 | | | | | | |
| Week: 7 | 11/19/2023 to 11/25/2023 | | | | | | | |
| Week: 8 | 11/26/2023 to 12/02/2023 | | | | | | | |
| Week: 9 | 12/03/2023 to 12/09/2023 | | | | | | | |

Allergies: NO KNOWN

| Current Medications | | | | | |
|---|---|---|---|---|---|
| **Medicine name and how to take** | **How much to take** | **When to take** | **Reason to take** | **Notes:** | **Agency Administered** |
| **Acetaminophen Extra Strength 500 Mg Tablet - Oral** | 2 tablet | 3 Times Daily - Take Only As Needed | Pain | | N |
| [redacted] | 1 tablet | Daily | [redacted] | | N |
| **Amiodarone 200 Mg Tablet - Oral** | 1 tablet | 2 Times Daily | Cardiac | | N |

# Patient Instructions Report



## RICK V. JOHNSON - DOB: [redacted]

[redacted]

Share any questions or concerns you have with your health care team.

MUNSON HOME CARE - MANISTEE, (800) 252-2065

| Current Medications | | | | | |
|---|---|---|---|---|---|
| **Medicine name and how to take** | **How much to take** | **When to take** | **Reason to take** | **Notes:** | **Agency Administered** |
| **Aspirin 81 Mg Tablet,Delayed Release - Oral** | 1 tablet | Daily | Antiplatelet | | N |
| **Atorvastatin 80 Mg Tablet - Oral** | 1 tablet | Daily | Cholesterol | | N |
| Carvedilol 12.5 Mg Tablet - Oral | 1 tablet | 2 Times Daily | Cardiac | | N |
| [redacted] | 1 capsule | 2 Times Daily - Take Only As Needed | [redacted] | | N |
| **Furosemide 40 Mg Tablet - Oral** | 1 tablet | 2 Times Daily | Diuretic | | N |
| **Gabapentin 100 Mg Capsule - Oral** | 1-2 capsule | 3 Times Daily - Take Only As Needed | Moderate Pain | | N |
| **Losartan 100 Mg Tablet - Oral** | 1 tablet | Daily | Htn | | N |
| **Magnesium 250 Mg (As Magnesium** Oxide) Tablet - Oral | 1 tablet | 2 Times Daily | Supplement | | N |
| [redacted] | 1 capsule | Daily | [redacted] | | N |
| **Spironolactone 25 Mg Tablet - Oral** | 1 tablet | Daily | Cardiac | | N |

# Patient Instructions Report



**RICK V. JOHNSON - DOB:** [redacted]

[redacted]

Share any questions or concerns you have with your health care team.

MUNSON HOME CARE - MANISTEE, (800) 252-2065

## Treatments

**SKILLED NURSE**

MANAGEMENT AND/OR TEACHING RELATED TO BLOOD PRESSURE
MANAGEMENT AND/OR TEACHING RELATED TO FALL PREVENTION
MANAGEMENT AND/OR TEACHING RELATED TO MEDICATIONS
MANAGEMENT AND/OR TEACHING RELATED TO PAIN CONTROL
MANAGEMENT AND/OR TEACHING RELATED TO SURGICAL INCISION